ARIZONA LONG TERM CARE SYSTEM

APPENDIX B

PREADMISSION SCREENING MANUAL

FOR

DEVELOPMENTALLY DISABLED (DD)

ISSUE DATE 8/95
EFF. DATE 9/1/95
REV. DATE 8/96
REV. DATE 5/01
REV. DATE 1/02

INTRODUCTION

Legislation

The Arizona State Legislature passed legislation in 1987 expanding the federally funded AHCCCS services to include long term care (LTC). As a result, the Arizona Long Term Care System (ALTCS) was established with an initial implementation date of December 19, 1988. To receive federal long term care Medicaid funds for an individual, AHCCCS Administration must demonstrate that the applicant/recipient (A/R) has a medical need for services and is at immediate risk of placement in a nursing facility (NF) or an intermediate care facility for the mentally retarded (ICF-MR).

On September 1, 1995, federally funded LTC services were expanded to include the ALTCS Transitional Program. This program allows currently eligible members who have improved and are no longer at risk of institutionalization but still require some LTC services, to receive HCBS services at a lower level of care. For more information on the Transitional Program see ALTCS Eligibility Policy and Procedures Manual, Chapter 1500, Section 1522.

LTC

Long Term Care refers to ongoing services required by individuals who are in need of care comparable to that received in a NF or an ICF-MR. These services represent a wide range of health related services above the level of room and board and offer professional services directed towards the maintenance, improvement, or protection of health or lessening of illness, disability or pain.

If, upon initial application, an applicant requires hospitalization or intensive inpatient rehabilitation, s/he is not considered at immediate risk of institutionalization at the NF or ICF-MR level, and is not eligible for ALTCS.

Preadmission Screening

Applicants/recipients (A/Rs) are determined by the Department of Economic Security, Division of Developmental Disabilities (DES/DDD) to be eligible for their services. These are A/Rs who have been diagnosed with mental retardation, cerebral palsy, seizure disorder or autism, and have significant impairment in their functions. For children under six years of age, a diagnosis of developmental delay or the risk for developmental disability may serve as the qualifying diagnosis for DES/DDD. The PAS process is intended to determine whether or not an A/R's current functional and medical condition, resulting from a developmental disability, indicates a need for services at the ICF-MR level. Frequently developmentally disabled individuals will be eligible to receive services from DES/DDD but not be at risk of institutionalization at the ICF-MR level.

There are four (4) preadmission screening tools or instruments, which are designed to evaluate A/Rs of different age groups. The groups are as follows:

Age 0-2…….. (birth through age two or up to the 3rd birthday)
Age 3-5…….. (three through five or up to the 6th birthday)
Age 6-11…….(six through eleven or up to the 12th birthday)
Ages 12…….. (beyond the 12th birthday)
and older

Children under six years of age who are not clients of DES/DDD (e.g., physically disabled children) will also be assessed using these tools.

PAS Eligibility

The DD PAS tools are used to assess the functional, medical and nursing needs of the A/R. Meeting or exceeding a threshold score on this screening tool establishes initial eligibility for institutional level of services (Arizona Revised Statutes §36-2936). A combination of weighted functional and medical factors are evaluated and assigned a numerical value to reach totaled scores. The purpose of the functional/medical threshold score is to ensure that all individuals deemed eligible for ALTCS require an ICF-MR level of care.

The eligible applicant needs long term care at a level of care comparable to that provided in an ICF-MR, but **below** an acute care setting (hospitalization or intense rehabilitation) and **above** a supervisory/custodial/personal care setting, intermittent outpatient medical intervention, or benevolent oversight. An initial applicant who is already enrolled with an AHCCCS acute health plan and who needs less than 90 days of convalescent care may also be ineligible for ALTCS. An A/R who does not have a non-psychiatric medical condition or developmental disability also may not be eligible.

In the aggregate, the eligible ALTCS client will have a functional and/or medical condition resulting in such a degree of impairment as to interfere substantially with the capacity to remain in the community, and results in long term limitation of capacity for self care.

Eligibility Review

When a client's medical eligibility for Title XIX services is not adequately defined by the scoring criteria, but in the ALTCS assessor's professional opinion the individual's overall condition may indicate need for ICF-MR level of care, the case may be referred for eligibility review to a consultant physician or an administrative review.

It is important to remember that there is no singular definition for the level of care for ALTCS medical eligibility. An eligible individual might have a combination of factors that impact functional ability and medical need for services.

Population Assessed

The population assessed with the DD tools includes persons with developmental disabilities (DD) and physically disabled children under 6 years of age who apply or are recipients of ALTCS. Developmentally disabled adults who are placed in nursing facilities are not assessed using this tool, but are assessed on the Elderly/Physically Disabled (EPD) tool. The PAS tool may also be used to determine whether individuals not applying for Title XIX services are at risk for ICF-MR care. These individuals will be assessed upon request (Private Request PAS).

Assessment Team

The tool is completed by a registered nurse and/or a social worker who will use professional judgment based on education, experience and ongoing inservice training to describe the A/R's functional ability and current medical status. If the A/R is ventilator dependent, the assessment will be conducted by a team composed of a nurse and a social worker. A thorough assessment will include a personal interview with the applicant and caregiver and a review of pertinent medical records or information as applicable.

HCBS

Long term care services may include home and community based services (HCBS) that offer an alternative to institutional care. ALTCS offers this alternative in order to ensure that the recipient in need of institutional level of care may be treated in the least restrictive environment. HCBS is appropriate for those who would require institutionalization, but who can retain a more independent lifestyle with services provided in the home and community setting.

Client Issue Referral (CIR)

When situations are identified that pose immediate and/or serious threat to the applicant's well being (e.g., quality of care, suicidal threats, environmental hazard, or suspected physical abuse or neglect), appropriate health providers and/or authorities (Adult/Child Protective Services, police, paramedics, guardians) as well as the assessor's supervisor, should be notified as soon as possible. Documentation of the referral (person notified, date and description of the incident) should be entered into the PAS case notes and/or an AHCCCS Client Issue Referral Form completed. For more information on CIR, see the ALTCS Eligibility Policy and Procedures Manual, Chapter 1500, Section 1519.

PASRR

The assessor should be aware that all nursing facility residents and applicants to Medicaid certified nursing facilities must be assessed through the Preadmission Screening and Resident Review (PASRR) process. The PASRR is a two-level screening process for mental illness/mental retardation and mandated by the Omnibus Budget Reconciliation Act of 1987 (OBRA '87) as a portion of NF reform measures. Although individuals with developmental disabilities are infrequently placed in NFs, the assessor must be aware of cases where the A/R is in a NF or is likely to enter one so that the PASRR may be completed. For further information regarding PASRR, see the ALTCS Eligibility Policy and Procedures Manual, Chapter 1500, Section 1520.

PAS Tool Sections

The ALTCS Preadmission Screening tool consists of several sections. These sections are:

- Intake information
- Functional assessment including developmental, independent living skills, behavioral and communication domains
- Medical assessment
- Eligibility review (if indicated)

This manual provides instructions for completing the PAS tool and guidelines for making assessment decisions. For more information regarding PAS and reassessments, see ALTCS Eligibility Policy and Procedures Manual, Chapter 1500.

CATS

The information on the completed tool will be entered into the computerized Client Assessment and Tracking System (CATS), which is the computer system supporting the PAS and case management functions.

I. INTAKE INFORMATION

A. REFERRAL INFORMATION

The PAS Intake Notice is generated from the Long Term Care Eligibility Determination System (LEDS) at the time of the PAS referral from Financial Eligibility. This will, in most cases, take the place of the first page of the PAS instrument. Page one (1) of the PAS tool will be available in the rare instance of the unavailability of the PAS Intake Notice or in the case of a Private Request PAS. In the descriptive fields listed below, asterisked fields (*) are those appearing on page one (1) of the PAS.

The PAS assessor should verify that the information on the PAS Intake Notice is complete and accurate, and should notify Financial Eligibility of changes or errors.

The PAS Intake Notice is comprised of the following fields:

Application Date

This is the date Financial Eligibility received the Application for AHCCCS Medical Benefits Part I.

Referral Date

This is the date Financial Eligibility referred the case for PAS.

PAS Due Date

This is the date the PAS is due. This date is six (6) days before the end of the application period for the case. The application period is 45 days from the application date.

LEDS CSLD (Caseload)

This is the caseload of the Financial Eligibility Interviewer assigned to the case.

EI (Eligibility Interviewer) Name

This is the name of the Financial Eligibility Interviewer assigned to the case.

PAS Site

This is the Medical Eligibility office assigned to complete the PAS. It will usually be the office where the application was taken, but the EI may refer the PAS to a different site if they know the client is placed in an area where another PAS office has authority.

DD (Developmental Disability) Status

This is the DD status at the time of referral.

1 = Potential DD
2 = DD
3 = DD in a Nursing Facility
4 = Not DD

If there is any question about DD status, this should be investigated and reconciled immediately. Status may be investigated by conferring with the EI and the Department of Economic Security, Division of Developmental Disabilities (DES/DDD). For more information on DD status, see ALTCS Eligibility Policy and Procedure Manual, Chapter 1500.

*** Client Age**

This is the A/R's age in years for A/Rs who are three (3) years or older, or in months for those under three years. The age is as of the referral date. Because the tools are age specific the assessor **must verify the A/R's age as of the PAS date. The age of the A/R on the date of the PAS determines the appropriate tool to be used. All children under 6 years of age will be assessed using the DD tools.** If the child is close to changing age groups (either months or years), the PAS may need to be delayed to ensure assessment with the proper tool.

AHCCCS Member?

Identifies if an ALTCS applicant is already eligible for AHCCCS acute services. Usually, these individuals are enrolled with an AHCCCS health plan. Often a PAS is done on a priority basis for health plan members. If an initial ALTCS applicant is a health plan member and is not expected to need more than 90 days of long term care, s/he may not be eligible for ALTCS. The acute health plan is responsible for up to 90 days of convalescent care. Cases that might belong in this category should be referred to the physician for eligibility review (please refer to section I on eligibility review). Any applicant that seems to need less than 90 days of convalescent care should have his/her AHCCCS health plan enrollment verified by reviewing computer screen RP285 or RP160. A name search can be conducted by using the RP290 screen.

*** Name**

The A/R's last name, first name and middle initial.

*** ACN (Application Control Number)**

This is the identifying number associated with the application. (Over time, an individual may have more than one (1) ACN which reflects that another application was completed).

*** DOB**

Date of Birth **(The assessor must always verify this date during the PAS interview)**. Because the tools are age specific, it is crucial that this date be accurate. If an error or inconsistency is found, it should be reported to the EI.

*** SSN**

Social Security Number.

*** Sex**

Male or Female.

*** Ethnic Code**

Ethnicity.

*** Language**

The applicant's primary language.

*** Marital Status**

Marital Status.

*** Residence Address (City, State, Zip Code)**

The A/R's address at the time of referral. If the applicant is in a facility, the facility address will be the residence address.

*** Mailing Address (City, State, Zip Code)**

The applicant's mailing address.

*** Residence County**

The county in which the applicant currently resides.

Client Rep

This is a contact person for the applicant. It may be the authorized representative, the legal representative or the closest living relative.

*** Res. Phone Number**

This is the applicant or contact person's residence phone number (if applicable).

Bus. Phone Number

This is the business phone number of the A/R's representative (if applicable).

*** Location Type (Location at Time of Referral)**

This is a code that describes the living arrangement of the applicant. If a PAS Intake Notice is not available, the assessor should write in the location and phone number at the time of the assessment as indicated on the form.

Facility

If the applicant is in an ICF-MR, hospital or nursing facility the AHCCCS provider number and name will appear here.

Phone

The facility phone number (if applicable).

*** Admission Date**

The date of admission to the facility (if applicable).

*** Date of Death**

The date of death will be on the PAS Intake Notice if the EI was aware at the time of the referral that the applicant was deceased.

If Different from Above

The Intake Notice has space at the bottom to indicate a change or a correction to residence address, mailing address, residence county and phone number, facility name and phone number, and admission date. Date of death may be entered, if applicable. Any other changes or corrections to the information on the Intake Notice should be written in under "Other Changes" and a copy sent to the EI.

*** Private Request PAS**

This will not be on the PAS Intake Notice printed by the system, but should be indicated on a paper referral (DE-126). A Private Request PAS would be done on an individual who is **not an applicant for ALTCS** but who requests, for whatever reason, to have PAS status determined.

B. ASSESSMENT INFORMATION

The PAS form includes information about the PAS Assessor(s) as well as demographic information about the applicant that must be obtained by the PAS assessor(s). For the most part, this is information that is not available from the LEDS system.

Date of Assessment

The date of the PAS interview should be indicated here.

PAS Assessor(s)

The six (6) value ID number and the name of the nurse and/or social worker completing the PAS should be entered here. Assessor's name should be printed, if using the paper tool.

C. DEMOGRAPHICS

Usual Living Arrangement

Select the applicable setting.

1. **Community** - An informal home setting such as family home or apartment.

2. **ICF-MR** - Intermediate Care Facility for the Mentally Retarded. Provides 24 hour care, including nursing, medical support, training, and therapeutic support to the residents.

3. **Group Home** - The most common community living arrangement that social service or private organizations establish for individuals who are mentally retarded, or have other disabling conditions. In these homes, a group lives within a residential neighborhood, receiving support and supervision.

4. **Residential Treatment Center** - An inpatient psychiatric facility for persons under the age of 21, accredited by the Joint Commission on Accreditation of Health Care Organizations (JCAHO), and licensed by ADHS as a residential treatment center pursuant to ADHS R9-5041.

5. **Other Supervised Setting** - Board and care homes, adult care homes, supervisory care homes, supervised apartments and alternative residential facilities.

Usual Living Situation

Select the item that applies starting with number one (**select only one**).

"Usual" would refer to the applicants current living situation for approximately the last six months or if the A/R has no discharge or relocation plans. (If an applicant resides in a facility in which another family member also resides, #5 "with non-relatives" should be indicated rather than living with spouse, parents, or other relative).

D. SOURCE OF INFORMATION

Indicate if the information for the interview was obtained by:
(Answer Yes or No to all)

1) Self report by the applicant;

2) Review of medical records;

3) Review of DES/DDD Case file;

4) Report by Informant/Caregiver. If an informant was used, indicate his/her full name and title or relationship if applicable.

In all cases the applicant must be observed and preferably the interview would occur in the usual living arrangement. **It is important that the interview be conducted with caregiver(s) or others familiar with the applicant.** It is required that family or legal guardian be contacted to be present at the PAS interview if they choose. If the family member or legal guardian is not available to attend the PAS, the assessor should contact them to go over the information obtained at the interview.

E. PERSONAL CONTACTS

This section is designed to elicit information about one personal contact, the applicant's physician, and the DES/DDD case manager. The personal contact's name may or may not be the same representative who has been identified by the EI. Indicate the contact's name, relationship to the applicant, address, and telephone numbers. Indicate whether or not the contact assisted with the interview. Do the same as above for the A/R's primary care physician and case manager. If medical documentation was received from the physician's office or if a diagnosis was confirmed by the office staff, this could be considered assisting with the interview process.

An addendum sheet is available in the event that the assessor needs to obtain and record information on additional contacts.

II. FUNCTIONAL ASSESSMENT - Part 1 (Ages 0-2)

A. DEVELOPMENTAL DOMAIN

The Developmental Domain is completed for children under age six (6), and therefore is found on the tools for ages zero (0) - two (2) and three (3) - five (5). The assessor should answer each question "yes" or "no" based on information provided by the caregiver, observation of the A/R and the medical record.

NOTE: If a child is close to a change in age that would indicate more developmental areas or a different PAS tool would be required, it may be beneficial to wait to do the assessment until after the age change. These cases should be discussed with a supervisor.

INFANTS LESS THAN SIX (6) MONTHS OLD

The PAS assessor should **not** complete Section A (Developmental Domain) **for infants less than six (6) months old**, but should proceed to the medical assessment section of the PAS (Section III) and complete that as accurately as possible. All pertinent medical documentation, including any other evaluations and assessments completed on the infant, must be copied. **This packet of information must then be submitted for physician review.**

Additionally for children under 6 months of age, a description of their emerging developmental patterns is required to be documented in regards to muscle tone, visual perception and social interaction. For example, does the child roll from stomach to side? Does the child follow moving objects with her/his eyes? Does the child smile or coo at a face or a touch? Use Summary Evaluation (section H) in the medical assessment section of the PAS tool (ages 0 to 2) to record this information.

CHILDREN SIX (6) MONTHS TO 36 MONTHS

There are six sections of developmental questions. **The assessor must accurately determine the A/R's age, and then complete only the particular section(s) applicable to the child.** The questions are divided at the following points:

For Children

- 6 months but less than 9 months old, only the first section is to be completed. (Questions 1-16)
- 9 months, but less than 12 months old, the first two sections are to be completed. (Questions 1-31)
- 12 months, but less than 18 months old, the first three sections are to be completed. (Questions 1-39)
- 18 months, but less than 24 months, the first four sections are to be completed. (Questions 1-46)

- 24 months, but less than 30 months, the first five sections are to be completed. (Questions 1-48)

- 30 months and older, complete all the questions.

All items are to be answered based on the child's performance <u>now</u>, not as s/he did or did not perform the skills at the ages indicated on the tool.

No sections or individual items required by the child's age may be skipped. If, for example, a 24 month old appears to have some basic skills at the 18 month level, all the earlier sections and items must still be accurately completed. **The assessor should try to avoid assuming that a child can perform skills based on her/his performance in other areas, as children may have scattered skills.** Scattered skills means the child may have varying levels of skills in several developmental areas.

The tool is designed to assess fine motor, gross motor, self help, social and language skills at different ages and therefore may show strengths and weaknesses within any section.

There are a few items which may be confusing to answer as the child gets older and learns more skills. As children progress they may learn new skills and no longer perform the precursors to those skills.

Examples are:

11. Does s/he "babble", repeat sounds together (e.g., num-num-num)?
26. Does s/he have at least one meaningful word other than "mama" or "dada"?

The child who now has meaningful words probably no longer babbles. But it would be a misrepresentation of the child's development to answer item 11 "No", when item 26 is "Yes". In this case the assessor does not need to determine whether the child did babble or can babble because s/he has moved beyond this stage to a higher level of development. In nearly all cases, if item 26 is answered "yes", item 11 should also be answered "yes".

Other examples of items that must be reviewed in this way are:

28. Does s/he hold own bottle? (May now drink from a cup).
46. Does s/he ask to be taken to the toilet? (May now go independently).

The child's performance of the higher skills is usually evidence that s/he is capable of performing similar skills that are more basic.

On questions pertaining to language and communication (e.g. 26, 36, 44, 45, 46), if the child uses Sign Language that should be considered in the scoring. Thus, if the child signs at least six real words, question 36 would be answered “Yes”.

FOR AGES SIX (6) MONTHS AND OLDER

1.	Does s/he support self on forearms when lying down?	Yes	No
2.	Does s/he hold head up steadily while on stomach?	Yes	No
3.	Does s/he lift head when lying on back?	Yes	No
4.	Does s/he roll from back to front?	Yes	No
5.	Are her/his hands usually open at rest?	Yes	No
6.	Does s/he pull at clothing?	Yes	No
7.	Does s/he transfer a toy from one hand to the other?	Yes	No
8.	Does s/he pick up small objects?	Yes	No
9.	Does s/he laugh or make happy noises?	Yes	No
10.	Does s/he turn her/his head to sound?	Yes	No
11.	Does s/he "babble", repeat sounds together (e.g., num-num-num)?	Yes	No
12.	Is s/he frightened by angry noise?	Yes	No
13.	Does s/he smile at you?	Yes	No
14.	Does s/he reach for familiar people or objects?	Yes	No
15.	Does s/he stretch arms out to be picked up?	Yes	No
16.	Does s/he show likes and dislikes?	Yes	No

STOP HERE IF CHILD IS LESS THAN NINE (9) MONTHS

17.	Does s/he sit for long periods without support?	Yes	No
18.	Does s/he pull up on furniture?	Yes	No
19.	Is s/he walking (alone or with hand held)?	Yes	No
20.	Does s/he pivot when sitting?	Yes	No
21.	Does s/he pick up objects with thumb and forefinger?	Yes	No
22.	Does s/he finger-feed any foods?	Yes	No
23.	Does s/he throw toys (objects)?	Yes	No
24.	Does s/he give you toys (let go) easily?	Yes	No
25.	Does s/he understand "no-no" or "bye-bye"?	Yes	No
26.	Does s/he have at least one meaningful word other than "mama" or "dada"?	Yes	No
27.	Does s/he shake head for "no"?	Yes	No
28.	Does s/he hold own bottle?	Yes	No
29.	Does s/he play any nursery games ("peek-a-boo", bye-bye")?	Yes	No
30.	Does s/he cooperate in dressing?	Yes	No
31.	Does s/he come when you call?	Yes	No

STOP HERE IF CHILD IS LESS THAN TWELVE (12) MONTHS

32.	Does s/he walk up stairs with help?	Yes	No
33.	Does s/he throw a toy while standing without falling?	Yes	No
34.	Does s/he turn book pages (2 to 3 at a time)?	Yes	No
35.	Does s/he fill spoon and feed self?	Yes	No
36.	Does s/he have at least six real words besides her/his "jargon"?	Yes	No
37.	Does s/he point at what s/he wants?	Yes	No
38.	Does s/he copy you in routine tasks (sweeping, dusting)?	Yes	No
39.	Does s/he play in the company of other children?	Yes	No

STOP HERE IF CHILD IS LESS THAN EIGHTEEN (18) MONTHS

40. Does s/he run well without falling? Yes No
41. Does s/he walk up and down the stairs alone? Yes No
42. Does s/he turn book pages one at a time? Yes No
43. Does s/he remove her/his own shoes and pants? Yes No
44. Does s/he talk in short (2-3 words) sentences? Yes No
45. Does s/he use pronouns ("me", "you", or "mine")? Yes No
46. Does s/he ask to be taken to the toilet? Yes No

STOP HERE IF CHILD IS LESS THAN TWENTY FOUR (24) MONTHS

47. Does s/he jump, getting both feet off the floor? Yes No
48. Does s/he hold a pencil or crayon adult fashion? Yes No

STOP HERE IF CHILD IS LESS THAN THIRTY (30) MONTHS

49. Does s/he pedal a tricycle? Yes No
50. Does s/he dry her/his hands (if reminded)? Yes No

II. FUNCTIONAL ASSESSMENT - Part 2 (AGES 3 - 5)

A. DEVELOPMENTAL DOMAIN

The developmental domain is completed for children under age six (6), and therefore is found on the tools for both ages zero (0) - two (2) and three (3) - five (5). The assessor should answer each question "yes" or "no" based on information provided by the caregiver, observation of the A/R and the medical record.

NOTE: If a child is close to a change in age that would indicate a different PAS tool would be required, it may be beneficial to wait to do the assessment until after the age change. These cases should be discussed with a supervisor.

Children Three (3) Years- Five (5) Years

All the developmental items should be answered for children who are three (3) through five (5) years old (third birthday up to sixth birthday). **All items are to be answered based on the child's performance now, not as s/he did or did not perform the skills at the ages indicated on the tool.**

No sections or individual items should be skipped. **The assessor should try to avoid assuming that a child can perform skills based on her/his performance in other areas, as children may have scattered skills.** Scattered skills means the child may have varying levels of skills in several developmental areas.

The tool is designed to assess fine motor, gross motor, self help, social and language skills at different ages and therefore may show strengths and weaknesses within any section.

There are a few items, however, that may be confusing to answer as the child gets older and learns more skills. As children progress they may learn new skills and no longer perform the precursors to those skills. Examples are:

11. Does s/he "babble", repeat sounds together (e.g., num-num-num)?
26. Does s/he have at least one meaningful word other than "mama" or "dada"?

The child who now has meaningful words probably no longer babbles. But it would be a misrepresentation of the child's development to answer item 11 "No", and item 26 "Yes". In this case the assessor does not need to determine whether the child did babble or can babble because s/he has moved beyond this stage to a higher level of development. In nearly all cases, if item 26 is answered "yes", item 11 should also be answered "yes". Other examples of items that must be looked at in this way are:

28. Does s/he hold own bottle? (May now drink from a cup)
46. Does s/he ask to be taken to the toilet? (May now go independently)

The child's performance of the higher skills is usually evidence that s/he is capable of performing similar skills that are more basic.

On questions pertaining to language and communication (i.e. 26, 36, 44, 45, 46), if the child uses Sign Language that should be considered in the scoring. Thus, if the child signs at least six real words, question 36 would be answered “Yes”.

FOR AGES SIX (6) MONTHS AND OLDER

1.	Does s/he support self on forearms when lying down?	Yes	No
2.	Does s/he hold head up steadily while on stomach?	Yes	No
3.	Does s/he lift head when lying on back?	Yes	No
4.	Does s/he roll from back to front?	Yes	No
5.	Are her/his hands usually open at rest?	Yes	No
6.	Does s/he pull at clothing?	Yes	No
7.	Does s/he transfer a toy from one hand to the other?	Yes	No
8.	Does s/he pick up small objects?	Yes	No
9.	Does s/he laugh or make happy noises?	Yes	No
10.	Does s/he turn her/his head to sound?	Yes	No
11.	Does s/he "babble", repeat sounds together (e.g., num-num-num)?	Yes	No
12.	Is s/he frightened by angry noise?	Yes	No
13.	Does s/he smile at you?	Yes	No
14.	Does s/he reach for familiar people or objects?	Yes	No
15.	Does s/he stretch arms out to be picked up?	Yes	No
16.	Does s/he show likes and dislikes?	Yes	No

FOR AGES NINE (9) MONTHS AND OLDER

17. Does s/he sit for long periods without support? Yes No
18. Does s/he pull up on furniture? Yes No
19. Is s/he walking (alone or with hand held)? Yes No
20. Does s/he pivot when sitting? Yes No
21. Does s/he pick up objects with thumb and forefinger? Yes No
22. Does s/he finger-feed any foods? Yes No
23. Does s/he throw toys (objects)? Yes No
24. Does s/he give you toys (let go) easily? Yes No
25. Does s/he understand "no-no" or "bye-bye"? Yes No
26. Does s/he have at least one meaningful word other than "mama" or "dada"? Yes No
27. Does s/he shake head for "no"? Yes No
28. Does s/he hold own bottle? Yes No
29. Does s/he play any nursery games ("peek-a-boo", bye-bye")? Yes No
30. Does s/he cooperate in dressing? Yes No
31. Does s/he come when you call? Yes No

FOR AGES TWELVE (12) MONTHS AND OLDER

32. Does s/he walk up stairs with help? Yes No
33. Does s/he throw a toy while standing without falling? Yes No
34. Does s/he turn book pages (2 to 3 at a time)? Yes No
35. Does s/he fill spoon and feed self? Yes No
36. Does s/he have at least six real words besides her/his "jargon"? Yes No
37. Does s/he point at what s/he wants? Yes No
38. Does s/he copy you in routine tasks (sweeping, dusting)? Yes No
39. Does s/he play in the company of other children? Yes No

FOR AGES EIGHTEEN (18) MONTHS AND OLDER

40. Does s/he run well without falling? Yes No
41. Does s/he walk up and down the stairs alone? Yes No
42. Does s/he turn book pages one at a time? Yes No
43. Does s/he remove her/his own shoes and pants? Yes No
44. Does s/he talk in short (2-3 words) sentences? Yes No
45. Does s/he use pronouns ("me", "you", or "mine")? Yes No
46. Does s/he ask to be taken to the toilet? Yes No

FOR AGES TWENTY-FOUR (24) MONTHS AND OLDER

47. Does s/he jump, getting both feet off the floor? Yes No
48. Does s/he hold a pencil or crayon adult fashion? Yes No

FOR AGES THIRTY (30) MONTHS AND OLDER

49. Does s/he pedal a tricycle? Yes No
50. Does s/he dry her/his hands (if reminded)? Yes No

II. FUNCTIONAL ASSESSMENT - PART 2 (AGES 3 - 5)

B. INDEPENDENT LIVING SKILLS DOMAIN

In selecting the best answers for children in the 3-5 age group on the following items, the assessor must insure that the answers selected are consistent with information in the previous section, Developmental Domain. For example, the following Developmental Domain items should correlate with the scores given in this section:

30. Does s/he cooperate in dressing?
43. Does s/he remove own shoes and pants?
46. Does s/he ask to be taken to the toilet?

The PAS assessor should rate activities as currently performed approximately 75% of the time. Credit should be given for what the A/R actually does, not what s/he "can do" or "could do" or "might be able to do".

- **DRESSING**

The A/R's ability to dress. This includes putting on and removing regular articles of clothing such as underwear, pants, shirts, dresses, socks, shoes. **This does not include braces, nor does it reflect the A/R's ability to match colors or choose clothing appropriate for the weather.** To physically participate means that the A/R takes part in the activity with some physical involvement of her/his body; not just being passive or cooperative.

SCORING

0) Completes the task independently.

1) Able to complete the task with verbal prompts, cue by touch, materials setup or other modifications (e.g., laying out of clothes).

2) Requires hands-on assistance to initiate/complete the task (e.g., help with fasteners).

3) Is not able to perform any part of this task but can physically participate.

4) Requires total hands-on assistance and does not physically participate.

- **ORIENTATION TO SETTINGS FAMILIAR TO INDIVIDUAL**

The A/R's orientation to **familiar** settings. These settings would usually include the A/R's own home, the school setting, and any other setting where the A/R spends enough time to be considered a familiar setting.

Physical assistance in this section refers to assistance needed due to cognitive deficits in orientation to setting. An individual who knows the way but requires physical assistance due to a physical disability, would be rated as independent.

SCORING

0) No problem in this area; knows way in all areas of familiar settings independently.

1) Knows way in part of, but not all of, familiar settings without prompting or physical assistance (e.g., to bedroom, bathroom).

2) Knows way from room to room within familiar settings with prompting; does not need physical assistance.

3) Does not know way from room to room within familiar settings without physical assistance.

- **TOILETING**

The A/R's ability to initiate and care for bladder and bowel functions. The ability to wash hands after toileting or the ability to transfer on and off the toilet should not be rated here.

If the A/R has bladder accidents, indicate the approximate frequency and select day [D], month [M] or year [Y]. Indicate in comments if accidents are only at night or in special situations (e.g., when on outing and away from familiar setting).

SCORING

0) Completes the task independently.

1) Able to complete the task with verbal prompts, cue by touch, materials setup, or other modifications.

2) Can indicate the need for toileting, but requires hands-on assistance to complete/perform the task (e.g., help with fasteners, toilet paper, flushing the toilet).

3) Does not indicate the need for toileting, but usually avoids accidents through a toileting schedule (e.g., periodic tripping by caregiver) and requires hands-on assistance to complete/perform the task.

4) Does not perform nor indicate the need for toileting and requires total caregiver intervention.

C. COMMUNICATION DOMAIN

In selecting the best answers for children in the 3-5 age group on the following item, the assessor must take care to insure that the answer selected is consistent with information in the previous section, Developmental Domain. For example, the following Developmental Domain questions also address the child's communication skills:

26. Does s/he have at least one meaningful word, other than "mama" or "dada"?
27. Does s/he shake head for "no"?
36. Does s/he have at least six (6) real words besides her/his "jargon"?
37. Does s/he point at what s/he wants?
44. Does s/he talk in short (2-3 words) sentences?
45. Does s/he use pronouns ("me", "you", or "mine")?
46. Does s/he ask to be taken to the toilet?

Rate communication as currently performed approximately 75% of the time.

- **CLARITY OF COMMUNICATION**

  A/R's ability to speak in a recognizable language or use a formal symbolic substitution, such as American Sign Language or alternate communication system. If A/R has more than one form of communication, score on what is best understood.

  SCORING

  0) Uses speech in a normal manner intelligible to an unfamiliar listener; no special effort is required to understand the individual.

  1) Speech understood by strangers with some difficulty; unfamiliar individuals can understand, but due to the lack of clarity, not all of the words are understood and the listener must pay close attention in order to understand.

  2) Uses a non-speech communication system that is understood by an unfamiliar listener (e.g., writing, communication board/device, gestures or pointing).

  3) Speech or other communication system understood only by either those who know the individual well or who are trained in the alternate communication system.

  4) Does not communicate using a recognizable language or formal symbolic substitutions.

D. BEHAVIORAL DOMAIN

The purpose of this section is to identify the presence of certain behaviors that may reflect the need for caregiver supervision and intervention. **In selecting the best answers for children in the 3-5 age group, the assessor must try to view the child's behavior in the context of the reasonable expectation of a child this age.** For example, sibling teasing or arguing that does not escalate to serious threats or acts of aggression may be considered normal in a child this age.

Responses for this section are based on both the frequency and the intensity of the behavior; that is the amount or degree of intervention required to control the problem behavior.

NOTE: It is important to note that to score behaviors the assessor must determine if the behavior is **minor**, **moderate**, **serious** or **extremely urgent**. That is determined generally by the intensity of the intervention and to a lesser degree, the frequency of the behavior. For example, a minor behavior such as whining may occur daily but not be a serious problem.

Rate behaviors over the last 90 days unless the scoring response requires you to go back to 1 year. The following definitions should be applied when answering questions related to behavior:

- **"Intervention"** — therapeutic treatment, including the use of medication, behavior modification and physical restraint to control the behavior. Intervention may be formal or informal and includes actions taken by friends/family to control the behavior (e.g., verbal or physical redirection; physical interruption).
- **"Physical Interruption"** — requires immediate physical (hands-on) interaction of the caregiver to stop the A/R's behavior.
- **"Occasional"** — less than weekly.
- **"Frequent"** — weekly to every other day.
- **"Constant"** — at least once a day.

NOTE: ALL BEHAVIOR IN THIS SECTION SCORED ABOVE A ZERO MUST BE DESCRIBED IN THE COMMENT SECTION AND INTERVENTION MUST BE SPECIFIED.

- **AGGRESSION**

  Aggressive behavior includes physical attacks on others, such as throwing objects, punching, biting, pushing, pulling hair, scratching. **Do not rate threatening or self-injurious behaviors as they are rated separately. Destruction of property alone or abuse of animals is not rated, but should be described in comments or summary section.**

  SCORING

  0) Problem does not occur or occurs at a level not requiring intervention.

  1) **Minor problem;** occasional aggression which requires some additional supervision in a few situations and/or verbal redirection.

  2) **Moderate problem;** frequent aggression that requires close supervision and/or physical redirection.

  3) **Serious problem;** constant aggression that requires close supervision and/or constant verbal or physical interruption.

  4) **Extremely urgent problem;** has had episode(s) causing injury in the last year; requires close supervision and physical interruption.

- **VERBAL OR PHYSICAL THREATENING**

  Behavior in which the A/R verbally or physically threatens to harm self, others or objects. **Do not include actual acts of physical aggression or self injurious behavior as they are rated elsewhere.**

  SCORING

  0) Problem does not occur or occurs at a level not requiring intervention.

  1) **Minor problem;** makes occasional threats which are not taken seriously and do not frighten others nor result in aggression from others; requires some additional supervision and/or verbal redirection.

  2) **Moderate problem;** makes frequent threats that sometimes cause fear and/or aggression from others; requires close supervision and physical redirection.

  3) **Serious problem;** makes constant threats that sometimes cause fear and/or aggression from others; requires close supervision and/or constant verbal or physical interruption.

  4) **Extremely urgent problem;** has had serious incident(s) in the last year; incidents always generate fear and/or are likely to result in aggression from others; requires close supervision and physical interruption.

- **SELF-INJURIOUS BEHAVIOR**

  Self-injurious behavior is defined as **repeated** behaviors that **cause injury** and may include biting, scratching, putting inappropriate objects into ear, mouth or nose, repeatedly picking at skin, head slapping or banging.

  SCORING

  0) Problem does not occur or occurs at a level not requiring intervention.

  1) **Minor problem;** occasional incidents which require some additional supervision in a few situations and/or occasional verbal redirection.

  2) **Moderate problem;** frequent incidents that require close supervision and/or physical redirection.

  3) **Serious problem;** constant incidents; requires close supervision and/or verbal or physical interruption.

  4) **Extremely urgent problem;** has had episode(s) causing serious injury requiring immediate medical attention in the last year; requires close supervision and/or physical interruption.

II. FUNCTIONAL ASSESSMENT - PART 3 (AGES 6 TO 11)

In scoring the functional section of the PAS, assessors should try to give credit for the highest level of a skill performed at least 75% of the time. **Credit should be given for what the A/R actually does, not what s/he "can do" or "could do" or "might be able to do".**

Rate activities/behavior as generally performed over the last year with emphasis on current functioning.

NOTE: If a child is close to a change in age that would indicate a different PAS tool would be required, it may be beneficial to wait to do the assessment until after the age change. These cases should be discussed with a supervisor.

A. MOTOR/INDEPENDENT LIVING SKILLS DOMAIN (ONE YEAR)

When an item groups many similar tasks into one (for example, Personal Hygiene is made up of brushing teeth, combing hair, washing face and hands), rate the A/R on the ability to complete the entire task. For example an A/R who needs hands-on help for brushing teeth, but only verbal prompts or no assistance for combing hair or washing face and hands should be scored a "2" on Personal Hygiene (requires hands-on assistance to initiate/complete the task).

When an A/R's skills are uneven (s/he can complete some parts of the task but not others) or variable (sometimes s/he does better than other times) **the assessor must determine the <u>best</u> response and explain in comments. If an A/R has characteristics of more than one response, the assessor must try to obtain more information in order to select the response that most closely describes the A/R's functioning and explain in comments.**

If it is clearly evident that an A/R is in need of more assistance than is received, the assessor may take that into consideration in scoring. This should be done conservatively as it may be difficult to determine the exact amount of assistance needed (e.g., only verbal assistance, not hands on assistance may be needed to attain a generally acceptable level of hygiene). **Explanation of this need must be documented in the comments and/or summary.**

Terms frequently used in this domain are defined below.

- **"Limited/Occasional"** — a small portion of an entire task (e.g., washing back only during bathing or washing feet only during bathing) or assistance required less than daily (e.g., shampooing).
- **"Physical Participation"** — active participation, not just being passive or cooperative.

- **<u>ROLLING and SITTING</u>**

The A/R's ability to roll and sit independently. "Sitting with support" may include either the physical support of another person or other types of support such as pillows or a specially made chair. **Indicate only <u>one</u> answer that best describes the highest level of skill attained.**

<u>SCORING</u>

0) Assumes and maintains sitting position independently.

1) Sits without support for at least five (5) minutes.

2) Maintains sitting position with minimal support for at least five (5) minutes.

3) Rolls from front to back and back to front.

4) Rolls from front to back only.

5) Rolls from side to side.

6) Lifts head and chest using arm support when lying on stomach.

7) Lifts head when lying on stomach.

8) Does not lift head when lying on stomach.

- **CRAWLING AND STANDING**

  The A/R's ability to crawl and stand. "Support" may include the help of another person or mechanical support, such as holding on to furniture.

  SCORING

  0) Stands well alone; balances well for at least five (5) minutes.

  1) Stands unsteadily alone for at least one (1) minute.

  2) Stands with support for at least one (1) minute.

  3) Pulls to a standing position.

  4) Crawls, creeps, or scoots.

  5) Does not crawl, creep or scoot.

- **AMBULATION**

  A/R's ability to walk. Consider the quality of the ambulation ("walks well" vs. "walks unsteadily") and the degree of independence of the ambulation ("walks alone" vs. "walks only with physical assistance from others"). Independent ambulation with an assistive device, such as a walker or cane, would still be considered "walking alone".

  SCORING

  0) Walks well alone for normal distances on all terrains.

  1) Walks well alone for a short distance (10-20 feet); balances well; distance limitation may be due to terrain.

  2) Walks unsteadily alone for short distance (10-20 feet).

  3) Walks only with physical assistance from others.

  4) Does not walk.

- **CLIMBING STAIRS OR RAMPS**

  A/R's ability to move up and down stairs or ramps. Rate for the use of ramps, rather than stairs, if the A/R uses a wheelchair or other assistive device not used on stairs. "Physical assistance" refers to assistance from another person.

  SCORING

  0) Moves up and down stairs or ramps without need for handrail.

  1) Moves up and down stairs or ramps with handrail independently.

2) Moves up and down stairs or ramps with physical assistance.

3) Unable to move up or down stairs or ramps.

- **WHEELCHAIR MOBILITY**

A/R's mobility using a wheelchair. Do not score the A/R's ability to transfer to the wheelchair. If a wheelchair is not used, indicate "0". The wheelchair may be motorized or manual. **If both are used, score according to the chair used the majority of the time.**

SCORING

0) Wheel chair is not used, or moves wheelchair independently.

1) Moves wheelchair independently, but with some difficulty (may move wheelchair with some bumping and/or difficulty in steering).

2) Individual needs some, but not total assistance, in moving wheelchair.

3) Needs total assistance for moving wheelchair.

- **DRESSING**

A/R's ability to dress. This includes putting on and removing regular articles of clothing such as underwear, pants, shirts, dresses, socks, shoes. **This does not include braces, nor does it reflect the A/R's ability to match colors or choose clothing appropriate for the weather.**

The use of adaptive clothing (elastic waist pants, velcro shoes or non-button shirts) does not disqualify the A/R from being considered independent. **The care of clothing (e.g., folding, putting away) is not rated.**

SCORING

0) Completes the task independently.

1) Able to complete the task with verbal prompts, cue by touch, materials setup, or other modifications (e.g., laying out of clothes).

2) Requires hands-on assistance to initiate/complete the task (e.g., help with fasteners).

3) Is not able to actively perform any part of this task but can physically participate.

4) Requires total hands-on assistance and does not physically participate.

- **PERSONAL HYGIENE**

  A/R's ability to perform Personal Hygiene tasks. This includes brushing teeth, washing face and hands, combing or brushing hair, nail care and use of deodorant if appropriate. **If the A/R performs the tasks at varying levels of independence, indicate the answer that best describes the A/R's overall ability in personal hygiene and explain in comments.** See page 25.

  SCORING

  0) Completes the task independently.

  1) Able to complete the task with verbal prompts, cue by touch, materials setup, or other modifications.

  2) Requires hands-on assistance to initiate/complete the task (e.g., put toothpaste on toothbrush or hands-on assistance to comb hair).

  3) This task must be done for the individual but individual can physically participate.

  4) Requires total hands-on assistance and does not physically participate.

- **BATHING OR SHOWERING**

  A/R's ability to complete the bathing process. This includes drawing the bath water, washing, rinsing and drying all parts of the body and shampooing hair. This also includes sponge or bed baths. The ability to wash face and hands when not bathing should be rated under Personal Hygiene, not Bathing or Showering. **The ability to transfer into the tub or shower is not rated.**

  SCORING

  0) Completes the task independently.

  1) Requires verbal prompts for washing and drying or physical help with drawing water, checking temperature.

  2) Requires extensive verbal prompts or limited/occasional hands-on assistance to complete task (e.g., shampooing or washing back).

  3) Requires hands-on assistance during entire bathing process but can physically participate.

  4) Requires total hands-on assistance and does not physically participate.

- **TOILETING**

  A/R's ability to initiate and care for bladder and bowel functions. The ability to wash hands after toileting should be rated under Personal Hygiene, not Toileting. **The ability to transfer on and off the toilet should not be rated here.**

SCORING

0) Completes the task independently.

1) Able to complete the task with verbal prompts, cue by touch, materials setup, or other modifications.

2) Can indicate the need for toileting, but requires hands-on assistance to complete/perform the task (e.g., help with fasteners, toilet paper, flushing the toilet).

3) Does not indicate the need for toileting, but usually avoids accidents through a toileting schedule (e.g., periodic tripping by caregiver) and requires hands-on assistance to complete/perform the task.

4) Does not perform nor indicate the need for toileting and requires total caregiver intervention.

- **LEVEL OF BLADDER CONTROL**

A/R's ability to control the elimination of urine. Evaluate the typical/usual bladder control level. Do NOT rate temporary occurrences due to acute illness or medication. **Make comments to indicate if accidents occur during day or at night, or both.**

SCORING

0) Complete control (no more than two accidents per year).

1) Some bladder control; accidents occur not as often as seven times per week (day or night).

2) Some bladder control; accidents occur at least seven times per week (day or night).

3) No control.

- **ORIENTATION TO SETTINGS FAMILIAR TO INDIVIDUAL**

The A/R's orientation to **familiar** settings. This would usually include the A/R's own home, the school setting, and any other setting where the A/R spends enough time to be considered a familiar setting.

SCORING

0) No problem in this area; knows way in all areas of familiar settings independently.

1) Knows way in part of, but not all of, familiar settings without prompting or physical assistance (e.g., to bathroom, bedroom or cafeteria).

2) Knows way from room to room within familiar settings with prompting; does not need physical assistance.

3) Does not know way from room to room within familiar settings without physical assistance.

B. COMMUNICATION DOMAIN (ONE YEAR)

• EXPRESSIVE VERBAL COMMUNICATION

Indicate the response that best describes the A/R's ability to communicate thoughts **verbally** with words or sounds (other forms of communication will be assessed in "Clarity of Communication").

SCORING

0) Carries on a complex or detailed conversation.

1) Carries on a simple brief conversation, such as talking about everyday events (e.g. the clothes you are wearing).

2) Uses simple two-word phrases (e.g., "I go", "give me").

3) Uses a few simple words and associates words with appropriate objects, such as names of common objects and activities.

4) Uses no words, but does use a personal language or guttural sounds to communicate very basic concepts.

5) Makes no sounds which are for communication; may babble, cry or laugh.

• CLARITY OF COMMUNICATION

Indicate the response that corresponds to the A/R's ability to speak in a recognizable language or use a formal symbolic substitution, such as American Sign Language. If A/R has more than one form of communication, score on what is best understood.

SCORING

0) Uses speech in a normal manner intelligible to an unfamiliar listener; no special effort is required to understand individual.

1) Speech understood by strangers with some difficulty; unfamiliar individuals can understand, but due to the lack of clarity, not all of the words are understood and the listener must pay close attention in order to understand.

2) Uses a non-speech communication system that is understood by an unfamiliar listener (e.g., writing, communication board/device, gestures, or pointing).

3) Speech or other communication system understood only by either those who know the person well or who are trained in the alternate communication system.

4) Does not communicate using a recognizable language or formal symbolic substitutions.

C. BEHAVIORAL DOMAIN (ONE YEAR)

The purpose of this section is to identify the presence of certain behaviors that may reflect the need for caregiver supervision and intervention. In selecting the best answers for children in this age group, the assessor must try to view the child's behavior in the context of the reasonable expectation of a child this age. For example, sibling teasing or arguing that does not escalate to serious threats or acts of aggression may be considered normal in a child within this age group.

Responses for this section are based on both the frequency and the intensity of the behavior; that is the amount or degree of intervention required to control the problem behavior.

NOTE: It is important to note that to score behaviors the assessor must determine if the behavior is **minor**, **moderate**, **serious** or **extremely urgent**. That is determined generally by the intensity of the intervention and to a lesser degree, the frequency of the behavior. For example, a minor behavior such as whining may occur daily but not be a serious problem.

Reminder: Rate activities/behaviors as generally performed over the last year with emphasis on current functioning.

The following definitions should be applied when answering questions related to behavior:

- **"Intervention"** therapeutic treatment, including the use of medication, behavior modification and physical restraints to control the behavior. Intervention may be formal or informal and includes actions taken by friends/family to control the behavior (e.g., verbal or physical redirection; physical interruption).
- **"Physical Interruption"** requires immediate physical (hands-on) interaction of the caregiver to stop the A/R's behavior.
- **"Occasional"** less than weekly.
- **"Frequent"** weekly to every other day.
- **"Constant"** at least once a day.

NOTE: ALL BEHAVIORS IN THIS SECTION SCORED ABOVE A ZERO MUST BE DESCRIBED IN THE COMMENT SECTION AND INTERVENTION MUST BE SPECIFIED.

- **AGGRESSION**

  Aggressive behaviors include physical attacks on others, such as throwing objects, punching, biting, pushing, pinching, pulling hair, scratching. **Do not rate threatening or self injurious behavior, as they are rated separately. Destruction of property alone or abuse of animals is not rated but should be described in comments or summary section.**

  SCORING

  0) Problem does not occur or occurs at a level not requiring intervention.

  1) **Minor problem;** occasional aggression which requires some additional supervision in a few situations and/or verbal redirection.

  2) **Moderate problem;** frequent aggression that requires close supervision and/or frequent verbal or physical redirection.

  3) **Serious problem;** constant aggression that requires close supervision and/or constant verbal or physical interruption.

  4) **Extremely urgent problem;** has had episode(s) causing injury in the last year; requires close supervision and physical interruption.

- **VERBAL OR PHYSICAL THREATENING**

  Behavior in which the A/R verbally or physically threatens to harm self, others or objects. **Do not rate actual acts of physical aggression or self-injurious behavior as they are rated elsewhere.**

  SCORING

  0) Problem does not occur or occurs at a level not requiring intervention.

  1) **Minor problem;** makes occasional threats which are not taken seriously and do not frighten others nor result in aggression from others; requires some additional supervision and/or verbal redirection.

  2) **Moderate problem;** makes frequent threats that sometimes cause fear and/or aggression from others; requires close supervision and/or frequent verbal or physical redirection.

  3) **Serious problem;** makes constant threats that sometimes cause fear and/or aggression from others; requires close supervision and/or constant verbal or physical interruption.

  4) **Extremely urgent problem;** has had serious incident(s) in the last year; incidents always generate fear and/or are likely to result in aggression from others; requires close supervision and physical interruption.

- **SELF-INJURIOUS BEHAVIOR**

  Self-injurious behavior is defined as **repeated** behaviors that **cause injury**, and may include biting, scratching, putting inappropriate objects in the ear, mouth or nose, repeatedly picking at skin, head slapping or banging.

  SCORING

  0) Problem does not occur or occurs at a level not requiring intervention.

  1) **Minor problem;** occasional incidents which require some additional supervision in a few situations and/or occasional verbal redirection.

  2) **Moderate problem;** frequent incidents that require close supervision and/or frequent verbal or physical redirection.

  3) **Serious problem;** constant incidents; requires close supervision and/or constant verbal or physical interruption.

  4) **Extremely urgent problem;** has had episode(s) causing serious injury requiring immediate medical attention in the last year; requires close supervision and physical interruption.

- **RUNNING OR WANDERING AWAY**

  Running or wandering away is defined as leaving the situation or environment inappropriately without either notifying or receiving permission from appropriate individuals as would normally be expected.

  0) Problem does not occur or occurs at a level not requiring intervention.

  1) **Minor problem;** occasional occurrences which may not pose a safety problem but do require some additional supervision and/or verbal redirection.

  2) **Moderate problem;** frequent occurrences pose minor safety issues to self or others; requires close supervision and/or physical redirection.

  3) **Serious problem;** constant occurrences pose safety issues to self or others; requires close supervision and physical redirection.

  4) **Extremely urgent problem;** occurs constantly or poses a very serious threat to the safety of self or others; requires close supervision and locked area.

- **DISRUPTIVE BEHAVIORS**

  Disruptive behaviors inappropriately interfere with the A/R's own activity or the activity of the caregiver or others and may include excessive whining, crying or screaming, persistent pestering, teasing, constant demands for attention, repetitious motions. Excessive hyperactivity, repetitive/stereotypic behaviors, or temper tantrums should be rated here. **Do not include verbal threatening or acts of physical aggression which are scored elsewhere.**

SCORING

0) Problem does not occur or occurs at a level not requiring intervention.

1) **Minor problem;** occurs occasionally and requires occasional intervention.

2) **Moderate problem;** occurs frequently and requires frequent intervention.

3) **Serious problem;** occurs constantly and requires constant intervention.

II. FUNCTIONAL ASSESSMENT - PART 4 (AGES 12 AND OLDER)

In scoring the functional section of the PAS, the assessors should give credit for the highest level of a skill performed at least 75% of the time. The goal is to describe the A/R's typical or usual functioning level. **Credit should only be given for what the A/R actually does, not what s/he "can do" or "could do" or "might be able to do."**

Rate activities/behaviors as generally performed over the last year with emphasis on current functioning.

A. MOTOR/INDEPENDENT LIVING SKILLS DOMAIN (ONE YEAR)

When an item groups many similar tasks into one (for example, Personal Hygiene is made up of brushing teeth, combing hair, washing face and hands) rate the A/R on the ability to complete the entire task. An example might be an A/R who needs hands-on help for brushing teeth, but only verbal prompts or no assistance for combing hair or washing face and hands. This A/R should be scored a "2" on Personal Hygiene (requires hands-on assistance to initiate/complete the task).

When an A/R's skills are uneven (s/he can complete some parts of the task but not others) or variable (sometimes s/he does better than other times) **the assessor must determine the best response and explain in comments. If an A/R has characteristics of more than one response, the assessor must try to obtain more information in order to select the response that most closely describes the A/R's functioning and explain in comments.**

If it is clearly evident that an A/R is in need of more assistance than is received, the assessor may take that into consideration in scoring. This should be done conservatively as it may be difficult to determine the exact amount of assistance needed (e.g., only verbal prompts, not hands on assistance may be needed to attain a generally acceptable level of hygiene). **Explanation of this need must be documented in the comments and/or summary.**

Terms relating to the frequency of a skill or behavior are defined below.

- **"Limited/Occasional"** a small portion of an entire task (e.g., washing back only during bathing or washing feet only during bathing) or assistance required less than daily (e.g., shampooing).

- ♦ **"Physical Participation"** active participation, not just being passive or cooperative.

- ♦ **"Physically Lift"** actively bearing some part of the A/R's weight during movement/activity (excluding bracing and guiding activity).

- **HAND USE**

A/R's ability to use her/his hands. Note that if the A/R has only one hand or has the use of only one hand, then scoring should be based on the use of the better hand. If that is the case, **it must be explained in comments.**

SCORING

0) Uses fingers independently of each other.

1) Uses thumbs and fingers of hand(s) in opposition.

2) Uses raking motion or grasps with hand(s).

3) No functional use of hand(s).

- **AMBULATION**

A/R's ability to walk. Consider the quality of the ambulation ("walks well" vs. "walks unsteadily") and the degree of independence of the ambulation ("walks alone" vs. "walks only with physical assistance from others"). Independent ambulation with an assistive device, such as a walker or cane, would still be considered "walking alone".

SCORING

0) Walks well alone for normal distances and on all terrains.

1) Walks well alone for a short distance (10-20 feet); balances well; distance limitation may be due to terrain.

2) Walks unsteadily alone for a short distance (10-20 feet).

3) Walks only with physical assistance from others.

4) Does not walk

- **WHEELCHAIR MOBILITY**

A/R's mobility using a wheelchair. Do not score the A/R's ability to transfer to the wheelchair. If a wheelchair is not used, indicate "0". The wheelchair may be motorized or manual. **If both are used, score according to the chair used the majority of the time.**

SCORING

0) Wheelchair is not used, or moves wheelchair independently.

1) Moves wheelchair independently, but with some difficulty (may move wheelchair with some bumping and/or difficulty in steering).

2) Individual needs some, but not total assistance in moving wheelchair.

3) Needs total assistance for moving wheelchair.

- **TRANSFER**

A/R's ability to transfer into the wheelchair, on and off the toilet, into and out of bed, and in and out of the shower/tub. Rate the degree of assistance necessary on a consistent basis. **Rate these items only with regard to the need for human intervention, not the need for assistive devices. Ability to transfer in and out of a vehicle is not rated.**

SCORING

0) No problem in this area; does transfer self independently but may require use of assistive devices.

1) Needs hands-on physical guidance, but does not have to be physically lifted, OR needs supervision with more than half of transferring activities.

2) Needs to be physically lifted or moved, but can participate physically.

3) Must be totally transferred by one or more persons OR is bedfast.

- **EATING/DRINKING**

A/R's eating and drinking abilities. Select 4 "tube fed" if tube feeding is the primary means of nourishment.

SCORING

0) Completes the task independently.

1) Able to complete the task with verbal prompts, cue by touch, materials setup, or other modifications (e.g., plate guard, built-up spoon, cutting of food).

2) Requires hands-on assistance to initiate/complete the task (e.g., place utensils in hand, hand-over-hand scooping, or other assistance).

3) Does not perform this task even when assisted; is fed.

4) A/R is tube fed.

- **DRESSING**

A/R's ability to dress. This includes putting on and removing regular articles of clothing such as underwear, pants, shirts, dresses, socks, shoes. **This does not include braces, nor does it reflect the A/R's ability to match colors or choose clothing appropriate for the weather.**

The use of adaptive clothing (elastic waist pants, velcro shoes or non-button shirts) does not disqualify the A/R from being independent. **The care of clothing (e.g., laundering, ironing) is not rated.**

SCORING

0) Completes the task independently.

1) Able to complete the task with verbal prompts, cue by touch, materials setup or other modifications (e.g., laying out of clothes).

2) Requires hands-on assistance to initiate/complete this task (e.g., help with fasteners).

3) Is not able to actively perform any part of this task but can physically participate.

4) Requires total hands-on assistance and does not physically participate.

- **PERSONAL HYGIENE**

A/R's ability to perform Personal Hygiene tasks. This includes hair care, brushing teeth, washing face and hands, shaving, nail care, menses care and use of deodorant. **If the A/R performs the tasks at varying levels of independence, indicate the answer that best describes A/R's overall ability in personal hygiene and explain in comments.** See page 36.

SCORING

0) Completes the task independently.

1) Able to complete the task with verbal prompts, cue by touch, materials setup, or other modifications.

2) Requires hands-on assistance to initiate/complete the task (e.g., put toothpaste on toothbrush or hands-on assistance to shave).

3) This task must be done for the individual but individual can physically participate.

4) Requires total hands-on assistance and does not physically participate.

- **BATHING OR SHOWERING**

  A/R's ability to complete the bathing process. This includes drawing the bath water, washing, rinsing and drying all parts of the body and shampooing hair. This also includes sponge or bed baths. The ability to wash face and hands when not bathing should be rated under Personal Hygiene, not Bathing or Showering. **The ability to transfer into the tub or shower is rated under Transfer.**

  SCORING

  0) Completes the task independently.

  1) Requires verbal prompts for washing and drying or physical help with drawing water, checking temperature.

  2) Requires extensive verbal prompts or limited/occasional hands-on assistance to complete task (e.g., shampooing or washing back).

  3) Requires hands-on assistance during entire bathing process but can physically participate.

  4) Requires total hands-on assistance and does not physically participate.

- **FOOD PREPARATION**

  A/R's ability to prepare simple meals for self. Simple meals may include sandwiches, hot dogs, cereals, frozen meals, eggs. **Do Not rate the A/R's ability to select a balanced menu or diet or to include a variety of food items.** Rate the item independent of the heating sources used (e.g., an A/R may use only the microwave and still be independent). **Explain such limitations in the comments.**

  Note: 75% of the time, for this area, would be one simple meal a day, 5 days a week.

  SCORING

  0) Completes the task independently.

  1) Able to complete the task with verbal prompts, cue by touch, materials setup, or other modifications.

  2) Requires hands-on assistance to initiate/complete the task.

  3) Does not perform this task, even when assisted; the task must be done for the person.

- **COMMUNITY MOBILITY**

  A/R's ability to move about the neighborhood or community independently, by any mode of transportation. **Score based on what s/he actually does, rather than what s/he "could do" or "might be able to do" if allowed.**

SCORING

0) Moves about the neighborhood or community independently without assistance.

1) Moves about the neighborhood or community independently for a complex trip (several stops, unfamiliar places, bus transfers) with instructions and/or directions.

2) Moves about the neighborhood or community independently for a simple direct trip and/or familiar locations with instructions and/or directions.

3) Moves about the neighborhood or community with some physical assistance and/or occasional accompaniment.

4) Moves about the neighborhood or community only with accompaniment.

- **TOILETING**

A/R's ability to initiate and care for bladder and bowel functions. The ability to wash hands after toileting should be rated under Personal Hygiene, not Toileting. **The ability to transfer on and off the toilet should be rated under Transfer.**

If the A/R has bladder accidents, indicate the approximate frequency and Select day [D] , month [M] or year [Y] . Indicate in comments if accidents are only at night or in special situations (e.g., when on outing and away from familiar setting).

SCORING

0) Completes the task independently.

1) Able to complete the task with verbal prompts, cue by touch, materials setup, or other modifications.

2) Can indicate the need for toileting, but requires hands-on assistance to complete/perform task (e.g., help with fasteners, toilet paper, flushing toilet).

3) Does not indicate the need for toileting, but basically avoids accidents through a toileting schedule (e.g., periodic tripping by caregiver) and requires hands-on assistance to complete/perform task.

4) Does not perform nor indicate the need for toileting and requires total caregiver intervention.

B. COMMUNICATION/COGNITIVE DOMAIN (ONE YEAR)

- **EXPRESSIVE VERBAL COMMUNICATION**

Indicate the response that best describes the A/R's ability to communicate thoughts **verbally** with words or sounds (other forms of communication will be assessed in "Clarity of Communication") .

SCORING

0) Carries on a complex or detailed conversation.

1) Carries on a simple brief conversation, such as talking about everyday events (e.g., the clothes you are wearing).

2) Uses simple two-word phrases (e.g., "I go", "give me").

3) Uses a few simple words and associates words with appropriate objects, such as names of common objects and activities.

4) Uses no words, but does use a personal language or sounds to communicate very basic concepts.

5) Makes no sounds which are for communication, may babble, cry or laugh.

- **CLARITY OF COMMUNICATION**

Indicate the response that corresponds to the A/R's ability to speak in a recognizable language or use a formal symbolic substitution, such as American Sign Language. If A/R has more than one form of communication, score on what is best understood.

SCORING

0) Uses speech in a normal manner intelligible to an unfamiliar listener; no special effort is required to understand individual.

1) Speech understood by strangers with some difficulty; unfamiliar individuals can understand, but due to the lack of clarity, not all of the words are understood and the listener must pay close attention in order to understand.

2) Uses a non-speech communication system that is understood by an unfamiliar listener (e.g., writing, communication board/device, gestures, or pointing).

3) Speech or other communication system understood only by either those who know the person well or who are trained in the alternate communication system.

4) Does not communicate using a recognizable language or formal symbolic substitutions.

- **ASSOCIATING TIME WITH EVENTS AND ACTIONS**

Indicate the response that best describes the A/R's ability to associate time with events and actions. **Note that the A/R's ability to actually tell time is not being assessed here.**

SCORING

0) Associates events with specific time (e.g., the concert starts at 7:45).

1) Associates regular events with specific hours (e.g., dinner is at six, work starts at eight, bedtime is at ten).

2) Associates regular events with morning, noon, or night (e.g., daily or weekly events, such as we go to school in the morning or I go to bed at night); does not understand time but knows the sequence of daily events.

3) Does not associate events and actions with time.

- **REMEMBERING INSTRUCTIONS AND DEMONSTRATIONS**

Select the response that corresponds to the A/R's ability to recall instructions or demonstrations on **how to complete specific tasks**. **Comments must include examples of tasks assessed.**

This is not remembering **to do** a task but remembering **how to do** the task. It is also not how long it took to learn but can the task now be done without prompts as to how to do the task. Examples of a task would be an independent living skill, household chore or vocational task. **It should not be a complex task or learning a new task.**

SCORING

0) Displays memory of instructions or demonstrations without prompting if they are given once.

1) Displays memory of instructions or demonstrations if they are given once and if prompted to recall.

2) Displays memory of instructions or demonstrations if they are repeated three or more times and if prompted to recall.

3) Displays no or extremely limited (rare or very incomplete) memory of instructions or demonstrations.

C. BEHAVIORAL DOMAIN (ONE YEAR)

The purpose of this section is to identify the presence of certain behaviors that may reflect the need for caregiver supervision and intervention. **Responses for this section are based on both the frequency and the intensity of the behavior; that is the amount or degree of intervention required to control the problem behavior.**

NOTE: It is important to note that to score behaviors the assessor must determine if the behavior is **minor**, **moderate**, **serious** or **extremely urgent**. That is determined generally by the intensity of the intervention and to a lesser degree, the frequency of the behavior. For example, a minor behavior such as whining may occur daily but not be a serious problem.

Reminder: Rate activities/behaviors as generally performed over the last year with emphasis on current functioning.

The following definitions should be applied when answering questions related to behavior:

- **"Intervention"** — therapeutic treatment, including the use of medication, behavior modification and physical restraints to control the behavior. Intervention may be formal or informal and includes actions taken by friends/family to control the behavior (e.g., verbal or physical redirection; physical interruption).
- **"Physical Interruption"** — requires immediate physical (hands-on) interaction of the caregiver to stop the A/R's behavior.
- **"Occasional"** — less than weekly.
- **"Frequent"** — weekly to every other day.
- **"Constant"** — at least once a day.

NOTE: ALL BEHAVIORS IN THIS SECTION SCORED ABOVE A ZERO MUST BE DESCRIBED IN THE COMMENT SECTION AND INTERVENTION MUST BE SPECIFIED.

- **AGGRESSION**

Aggressive behaviors include physical attacks on others, such as throwing objects, punching, biting, pushing, pinching, pulling hair, scratching. **Do not rate threatening or self-injurious behavior, as they are rated separately. Destruction of property alone or abuse of animals is not rated, but should be described in comments or summary section.**

SCORING

0) Problem does not occur or occurs at a level not requiring intervention.

1) **Minor problem;** occasional aggression which requires some additional supervision in a few situations and/or verbal redirection.

2) **Moderate problem;** frequent aggression that requires close supervision and/or frequent verbal or physical redirection.

3) **Serious problem;** constant aggression that requires close supervision and/or constant verbal or physical interruption.

4) **Extremely urgent problem;** has had episode(s) causing injury in the last year; requires close supervision and physical interruption.

- **VERBAL OR PHYSICAL THREATENING**

  Behavior in which the A/R verbally or physically threatens to harm self, others or objects. **Do not rate actual acts of physical aggression or self-injurious behavior as they are rated elsewhere.**

  SCORING

  0) Problem does not occur or occurs at a level not requiring intervention.

  1) **Minor problem;** makes occasional threats which are not taken seriously and do not frighten others nor result in aggression from others; requires some additional supervision and/or verbal redirection.

  2) **Moderate problem;** makes frequent threats that sometimes cause fear and/or aggression from others; requires close supervision and/ or frequent verbal or physical redirection.

  3) **Serious problem;** makes constant threats that sometimes cause fear and/or aggression from others; requires close supervision and/or constant verbal or physical interruption.

  4) **Extremely urgent problem;** has had serious incident(s) in the last year; incidents always generate fear and/or are likely to result in aggression from others; requires close supervision and physical interruption.

- **SELF-INJURIOUS BEHAVIOR**

  Self-injurious behavior is defined as **repeated** behaviors that **cause injury**. Self-injurious behaviors may include biting, scratching, putting inappropriate objects into ear, mouth or nose, repeatedly picking at skin, head slapping or banging. **Do not include medical non-compliance issues or behaviors that might be considered life style choices (e.g., sexual activity, smoking, non-compliance with dietary restrictions).**

  SCORING

  0) Problem does not occur or occurs at a level not requiring intervention.

  1) **Minor problem;** occasional incidents which require some additional supervision in a few situations and/or occasional verbal redirection.

  2) **Moderate problem;** frequent incidents that require close supervision and/or frequent verbal or physical redirection.

  3) **Serious problem;** constant incidents; requires close supervision and/or verbal or physical interruption.

  4) **Extremely urgent problem;** has had episode(s) causing serious injury requiring immediate medical attention in the last year; requires close supervision and physical interruption.

- **RESISTIVENESS/REBELLIOUSNESS**

Resistiveness/Rebelliousness is defined as inappropriate stubborn or uncooperative behaviors, including passive or active obstinate behaviors. Do not include difficulties with processing of information (those who are slow to respond) or reasonable expressions of self advocacy. **Do not rate threatening or aggressive behaviors, as they are rated elsewhere. Comments for this item must specifically describe the behaviors and the intervention required.**

SCORING

0) Problem does not occur or occurs at a level not requiring intervention.

1) **Minor problem;** occurs occasionally and requires occasional attention, prompting and/or verbal redirection for cooperation.

2) **Moderate problem;** occurs frequently and requires frequent attention, prompting and/or physical redirection for cooperation.

3) **Serious problem;** occurs constantly and requires constant attention, prompting and/or physical redirection for cooperation.

III. MEDICAL ASSESSMENT

The primary source of information for the Medical Assessment section of the PAS should be the A/R's medical records. The purpose of this section is to determine the A/R's medical status by evaluating the medical conditions, sensory functions and need for medical services. If the A/R is in an ICF-MR or resides in a group home, much of the information may be obtained directly from their records. **If a home interview is conducted, A/R and/or caregiver report may be used, but every attempt must be made to obtain verification of pertinent facts from the A/R's medical records, physician or other health care providers, or others who are well informed regarding the A/R (e.g., the case manager).** When completed, this section should give a thorough picture of the A/R's current medical condition and immediate medical and nursing needs.

A. MEDICAL CONDITIONS

This section is used to record the A/R's diagnoses and specific medical conditions. It includes a listing of frequently occurring conditions in A/Rs with developmental disabilities. The assessor should review each category of conditions listed to ensure that no significant diagnoses are omitted. **All Diagnosed Conditions must be INDICATED BY SELECTING THE CONDITION**.

* NEUROLOGICAL/CONGENITAL/DEVELOPMENTAL CONDITIONS (1-6)

Most A/Rs will have at least one of the conditions listed in this section, and many will have more than one. If an A/R has mental retardation, but the level is not specified in the records reviewed, identify the diagnosis as "Unspecified Mental Retardation". If the diagnosis is indicated as Educable Mentally Handicapped (EMH), indicate Mild Mental Retardation. If the diagnosis is indicated as Trainable Mentally Handicapped (TMH), indicate Moderate Mental Retardation. **Every effort must be made to identify the level of the A/R's Mental Retardation. The A/R's most current evaluation with test results relating to IQ must be used however we cannot interpret an IQ as a diagnosis**.

If there is conflicting information in the records available, the diagnosis must be reviewed by a medical eligibility manager to determine if there is enough information to indicate a level of mental retardation. In most cases we should have a psychological evaluation with the diagnosis indicated. If the diagnosis is indicated as mild to moderate, 3.E. Unspecified Mental Retardation should be indicated. If the diagnosis is indicated as moderate to severe or severe to profound, indicate the higher level of functioning and explain in comments. For example 3.C. Severe Mental Retardation should be indicated if the diagnosis is Severe to Profound.

* OTHER MEDICAL CONDITIONS (7-16)

Many A/Rs will have other medical conditions as listed in Section III A 7-16 in addition to their specific developmental disability. These should be indicated. If a specific stated diagnosis is not listed in category 1 through 16, but the diagnosis or condition is the same or essentially the same as one of the listed conditions, the preprinted condition may be selected and the comment section used to elaborate. For example, if the stated diagnosis is atrial-septal defect, then indicate 8.C., Congenital Anomalies of the Heart **and note the specific defect in comments.**

* OTHER DIAGNOSES (17)

The assessor should identify any other significant diagnoses in category 17. An ICD-9 CM code and description of these other diagnoses should be indicated in the blanks provided. **DO NOT list surgical procedures as diagnoses. They may be recorded in the comments section.**

* ACUTE (A), CHRONIC (C), HISTORY (H)

The assessor should further describe the medical conditions indicated by selecting the appropriate letter for Acute, Chronic or History. The definitions for A, C, H are:

- "Acute" An active condition having a sudden onset, lasting a short time and requiring intervention. The condition may still be considered acute if the A/R is in a convalescent stage of an acute illness.

- "Chronic" A condition which is either always present or occurs periodically, or is marked by a long duration. If an A/R is being treated for a condition over a long period, the condition would probably be considered chronic. For example, a seizure disorder that is controlled with medication would be considered chronic rather than historical.

- "History" A condition which occurred in the past, may or may not have required treatment, but is not currently active. If possible, the approximate date of the condition should be noted for historical diagnoses. If the date is not available, then it must be documented in the comments approximately how long ago the condition occurred.

NOTE: ONLY ONE DIAGNOSIS IN THE CATEGORY OF MENTAL RETARDATION CAN BE INDICATED AS CHRONIC (C) AND NONE CAN BE INDICATED AS ACUTE (A).

* COMMENTS

Comment lines are provided to clarify any diagnosis indicated. **Comments should always be included for any diagnosis of seizure disorder.**

The assessor should provide a description of:

- each type of seizure;
- the frequency of each type;
- and the date of the last seizure. If the seizures are infrequent, these may be approximates.

Comments should always be included for any condition marked which would be considered a general category. For example, items such as (16.d.) Behavior Disorders, (6.j.) Genetic Anomalies, or (6.l.) Congenital Anomalies should have a clarifying comment as to the specific condition.

As previously mentioned, conditions that are marked as historical must be explained with a date or with an approximate time frame, such as "about 4 years ago".

* MAJOR DIAGNOSES

The assessor should select up to three (3) major diagnoses using the already selected category and condition codes from the prior section. The major diagnoses may be obtained from medical records or if not specified, the assessor may determine which diagnoses are most significant based on which ones are most resource intensive (requiring the most hands on assistance) or causing the most significant medical and functional problems for the A/R.

By Arizona Revised Statue an eligible person must have a non-psychiatric medical condition or developmental disability, that by itself or in combination with other medical conditions, places the person at risk of institutionalization in a nursing facility or intermediate care facility for the mentally retarded. Therefore, an eligible person must have a non-psychiatric major diagnosis. See page 61 for more information on physician review on eligible cases with SMI diagnosis.

B. SERVICES AND TREATMENTS

Indicate (R) receives or (N) needs for each service or treatment that the A/R is either currently receiving or for which s/he has a documented need. **If a Need is indicated, the assessor must explain in comments. The determination of need should be based on documentation, such as physician order, the recommendation of a therapist, or a clearly defined medical condition for which the service is routine treatment.**

Do not consider recently discontinued services; however, it may be pertinent to mention these in the comment section. You may indicate as "Receives", services that are intermittent but ongoing (such as chemotherapy).

If an A/R Receives or Needs none of the services in this section, make a note to that effect in comments. If an A/R self-administers a service or treatment, it should be indicated that s/he Receives the service and a comment should be made. If the A/R is receiving a service which is not adequate, put an (R) in the space provided and use the comments section or summary to explain.

* FREQUENCY OF SERVICE

Indicate the frequency of services by selecting (C) for continuously, (D) for daily to several times daily, (W) for weekly to 3 times a week (if more often than 3 times a week consider daily), and (M) for monthly or greater. An ongoing service or treatment which lasts several hours or more may be considered continuous (e.g., tube feeding or oxygen at night only).

It may be necessary to include comments to clarify the frequency of some treatments in order to help identify the severity of the condition (e.g., apnea monitor during naps and at night). Frequency does not need to be indicated when a service is indicated as (N) needs.

1. Injections/IV

a. Intravenous Infusion Therapy - Fluid substance introduced into the body via a vein. This includes blood transfusions.

b. Intramuscular/Subcutaneous Injections - Fluid substance injected into the muscle or beneath the skin via a hypodermic syringe.

2. Medications/Monitoring

a. Drug Regulation - The necessity for close evaluation/ monitoring/ adjustment of medications to assure effective therapeutic value.

Some examples of drug regulation might include:

- Periodic lab test: blood sugar levels for antidiabetic, anticonvulsant blood levels (e.g., Tegretol, Dilantin), psychotropic drug levels (e.g., Haldol, Lithium), cardiac drug levels (e.g., Digoxin, Lasix);

- Adjustment of medication dosage/schedule in direct relation to diagnostic testing or symptoms: Hold Lanoxin if pulse below 60, hold Procardia if systolic blood pressure below 150, sliding scale for insulin dosage;

- Intense supervision or observation that is needed to evaluate: adverse reactions, interactions, or immediate response to a drug such as a narcotic or chemical restraint (e.g., Demerol, Haldol, Mellaril).

- "Drug regulation" is not meant to refer to routine monitoring/evaluation/adjustment that is appropriately and readily accomplished by non-professionals (e.g., "Aspirin upsets my stomach so I'll take Tylenol instead").

b. Drug Administration - Giving or applying medication to remedy an illness or condition. Includes self administration.

3. **Dressings**

a. Decubitus Care - Application of various materials or treatments such as Duoderm, Santyl, Collagenase, Betadine, ointments, bandages, heat application, whirlpool and debridement for therapeutic reasons to protect or assist in healing a pressure sore or stasis ulcer. Include preventative measures ordered by the physician for A/Rs with histories of chronic difficulties which are likely to recur. **Use the comments section to describe the stage of the ulcer.**

b. Wound Care - Application of various materials such as medicated solutions, ointments, gauze and bandages to assist in the healing or protection of a wound (incision, skin tears, burns, IV sites, dialysis sites) for therapeutic reasons. This does **not** include simple first aid measures or medications applied to skin conditions such as acne or dry skin. **Use the comments section to describe the wound and the specific treatment if not described elsewhere in the PAS.**

c. Other ostomy care - Specific care needs, such as irrigation, cleaning or bandaging to maintain an artificial opening or a stoma. This refers to ostomy care other than for bowel or bladder ostomies, (covered in 5.b.) or tracheostomies (covered in 6.e.). Examples of other ostomies are gastrostomy and jejunostomy.

4. **Feedings**

a. Parenteral Feeding/TPN - Nutrition administered intravenously.

b. Tube Feeding - Nutrition administered through a tube (such as nasogastric, gastrostomy or jejunostomy tubes) to the alimentary tract.

5. **Bladder/Bowel**

a. Catheter Care - Maintenance of catheter patency and hygiene. Includes condom, indwelling and intermittent straight catheterization.

b. Ostomy Care - Specific care (i.e., changing stoma ring, changing bag) necessary to maintain an artificial opening or stoma which is used for emptying bowel or bladder contents.

c. Bowel Dilatation - Expansion of the anal orifice to promote evacuation.

6. **Respiratory**

   a. Suctioning - Removing or withdrawing secretions and waste material.

   b. Oxygen - Receiving O_2 per nasal prongs, face mask or tent.

   c. SVN (small volume nebulizer) - Treatment using a machine that produces a fine spray or mist of a specific prescription for inhalation (exclude hand held atomizers/inhalers).

   d. Ventilator - A mechanical device for artificial ventilation of the lungs usually administered per tracheostomy (excludes C-PAP and Bi-PAP without a rate setting).

   e. Trach Care - Suctioning and cleaning the stoma and the apparatus that provides an artificial airway to the lungs through the trachea.

   f. Postural Drainage - Positioning so that gravity will allow drainage from nasal passages, airways and sinuses. Drainage is usually stimulated by percussion to the lung areas.

   g. Apnea Monitor - A monitoring device which sounds an alarm when respiration or heart rate go above or below preset parameters. **Comments should be included as to use (e.g., continuously or at night only).**

7. **Therapies**

   a. Physical - Treatment provided for specific physical problems by or under the direction of a registered physical therapist. Therapies may involve use of hydrotherapy, exercises, electricity, radiation, and training in use of assistive devices (e.g., braces, sidelyer, stander).

   b. Occupational - Treatment provided by or under the direction of a registered occupational therapist that will assist the A/R in the management of personal care. This therapy helps to improve the A/R's functional abilities, teaches adaptive techniques for ADLs and works with upper extremity mobility and fine motor skills.

   c. Speech - Treatment provided by or under the direction of a registered speech therapist for various speech and swallowing/feeding difficulties. Therapy helps the A/R with comprehension, speech and feeding difficulties, and provides diagnostic/evaluation services.

   d. Respiratory - Treatment provided by or under the direction of a registered respiratory therapist to restore, maintain and improve respiratory function (includes the use of C-PAP which is an exception as it **MAY** or **MAY NOT** be under the direction of or provided by a registered respiratory therapist).

e. Alcohol/Drug Treatment - Medical or psychological counseling aimed at A/Rs who abuse alcohol and/or mood altering drugs. May include self-help groups (treatment should be for A/R, not family members).

f. Vocational Rehabilitation - Therapy directed at developing or redeveloping job-related skills.

g. Individual/Group Therapy - Psychotherapy or counseling provided by a professional for treatment of mental or emotional disorders or maladjustment.

h. Behavior Modification Program - A specific program developed to address and redirect A/R's inappropriate behavior under the direction of a psychologist or mental health professional. The program must include written record keeping of behavioral incidents and progress.

8. **Rehabilitative Nursing**

a. Teaching/Training Program - Teaching an A/R or family caregiver routine tasks in relation to A/R's medical need (e.g. tube feeding, ostomy care, postural drainage/chest percussion, diet planning/Prader-Willi food precautions, use of prosthesis, self administration of medication).

b. Bowel/Bladder Retraining - A formal method of reestablishing regular evacuation/urination. **Does not include routine/initial toilet training in children or tripping schedule.**

c. Turning and Positioning - Moving, turning or repositioning an A/R who is not able to move independently. This is done to improve circulation and to avoid decubiti or contractures.

d. Range of Motion - Active or passive exercise with the goal of restoration of a specific function or maintenance of function. This excludes general exercises to promote overall fitness.

e. Other Rehab Nursing - Other rehab nursing services deemed appropriate to regain health or strength, under the direction of nurses or therapists, that is reasonable and justified (e.g. restorative ambulation, restorative feeding, deep breathing exercises, therapeutic splinting).

9. **Other Services And Treatments**

a. Peritoneal Dialysis - Removal of waste products from the body by perfusing prescription solutions through the peritoneal cavity.

b. Hemodialysis - Removal of waste products by circulating the body's blood supply through special dialyzing tubes.

c. Chemotherapy/Radiation - The application of chemical or x-ray agents that have a specific and toxic effect on cancerous cells.

d. Restraints - Devices that hinder or restrict movement to protect an A/R from injury.

Mechanical: Physical devices or barriers that restrict normal access to one's body or immediate environment and to protect from injury. May include devices (attached or adjacent to the body) that cannot be easily removed such as vest, seat belts, or barriers to normal, standard movement (e.g., locked rooms or areas). Usually, devices such as side rails or self-removable seat belts will **not** be considered restraints.

Chemical: Prescribed medication used for elimination or modification of **overt physical behaviors** likely to cause physical harm to self or others (e.g., combativeness, constant pacing, or self mutilation).

A specific drug must be linked with a particular behavior and used to eliminate or control the specific behavior.

Verbal reminders/redirection by others, shielding, deflecting, guiding or bracing a body part for completion of a procedure is not a restraint.

NOTE: The specific type of restraint and the reason it is being used must be documented in comments.

e. Fluid Intake/Output - Measuring and monitoring the oral and parenteral intake of fluids and/or all the fluid output (e.g., IV fluids, tube feedings, parenteral feedings, specific fluid intake or urine output, catheter output, vomitus and other fluid loss). Routine recording of dietary intake or supplements is not I & O.

f. Other - Includes other treatments prescribed for a specific problem (e.g., special mattress, whirlpool). Any service or treatment received or needed **but not documented elsewhere** should be indicated here.

C. MEDICATIONS/TREATMENTS

This section identifies the medications and treatments currently received by the A/R. **If in a facility, the assessor may photocopy medication orders from the A/R's medical records and indicate which are in current use.** If the interview is in-home, request prescription containers and copy label information. If there is a discrepancy between the verbal report, prescription bottles and/or the medical records, note it in the comments section. Also ask if the A/R is taking any type of non-prescription medication. The assessor should include dosage, frequency, duration, route and form of each medication. If the A/R receives a PRN medication, note the prescribed frequency as well as the actual frequency taken on prescription medications or if significant on over-the-counter (OTC) medications.

D. MEDICAL STABILITY

A (Y) yes in this section requires an explanation in the comment section.

1. Hospitalizations — Indicate the number of hospitalizations the A/R has had in the last year. This may be approximate, based on caregiver report. Make comments as to the reason for each hospitalization and approximate date if known. This does not include ER visits, but these may be mentioned in the comment section.

   Do not include birth as a hospitalization for an infant or young child unless the hospitalization continued due to the child's medical problems.

2. Caregiver Training — Indicate **(Y)** yes for this item if the A/R requires a direct care staff or caregiver to be trained in **special health care procedures.** These procedures (e.g. ostomy care, positioning for medical necessity, use of adaptive devices, SVN, behavior modification, seizure precautions, [if current seizure activity]) **should be those normally performed or monitored by licensed staff, such as an R.N. or a Therapist**.

   Do include training for procedures that are intermittent but on-going (i.e. SVN's seasonally). **Make comments as to the procedure and who is trained.**

   Do not include personal care that would not require special training, such as routine help with ADLs or applying AFO's or a simple brace.

   Do not include training for a procedure that the A/R has received in the past **but no longer routinely requires.**

3. Special Diet — Indicate **(Y)** yes for this item if the individual requires a special diet ordered by a physician, planned by a dietitian, nutritionist or nurse (e.g., high fiber, low calorie, low sodium, pureed) and **write in the type of diet in the comments section. This would include formula for tube feedings but would not include formula for infants and young children who typically receive one of a variety of infant formulas.**

E. SENSORY FUNCTIONS

This section will be used to evaluate hearing and vision. Assessment may be made by reviewing available information from the caregiver, applicant, medical records and observation.

If the assessor is unable to assess the impairment, this will be scored in the "0" or unimpaired category.

A/Rs who are unable to respond due to coma will be scored as having maximum impairment.

- **HEARING**

Hearing refers to the ability to receive sounds, and does not refer to the ability to comprehend mentally the meaning of sound. If an assistive device is used, hearing should be rated while using the device.

SCORING

0) Unable to Assess/No Impairment. Hears all normal conversational speech, including when using the telephone, watching television, and participating in group activities, or unable to assess.

1) Minimal Impairment. Has difficulty hearing when not in quiet surrounding. May have impairment in one ear but may hear adequately with the other ear.

2) Moderate Impairment. Although hearing-deficient, compensates when speaker adjusts tonal quality and speaks distinctly; or can hear only when a speaker's face is clearly visible.

3) Severe Impairment. Highly impaired/absence of useful hearing; hears only some sounds; frequently fails to respond even when speaker adjusts tonal quality, speaks distinctly, or faces A/R.

- **VISION**

Vision refers to perceiving objects visually. In this section, the assessor will evaluate the A/R's ability to see close objects and objects at a distance in adequate lighting, using any visual appliances (e.g., glasses, magnifying glass). **A medical condition or disease affecting the eye that does not affect the ability to see should not be considered in determining adequacy of sight.**

SCORING

0) Unable to Assess/No Impairment. There is no impairment or impairment is compensated by corrective lenses (e.g., can see newsprint, TV, medication labels) or unable to assess.

1) Minimum Impairment. Difficulty with focus at close (reading) range but can see large print and obstacles but not details. May be blind in one eye but has been able to compensate.

2) Moderate Impairment. Very poor focus at close range. Unable to see large print and/or field of vision is limited (tunnel vision or central vision loss).

3) Severe Impairment. May only see light, shapes, colors, or has no vision.

F. PHYSICAL MEASUREMENTS

1. Height - Record approximate height if actual is unknown. Respond in feet and/or inches rather than using the metric system.

2. Weight - Record approximate weight if actual is unknown. Respond in pounds rather than using the metric system. Record ideal weight range if available.

3. Measurements at Birth - For A/Rs who are below the age of 6, record the gestational age in weeks and birth weight.

G. ADDITIONAL INFORMATION

1. Is the applicant currently hospitalized or in an intensive rehabilitation facility?

   Answer **yes** or **no** as applicable. If you indicated **no**, skip to question 3 of this section.

2. If in an acute facility, is discharge imminent?

   Answer **yes** or **no**. If discharge is not anticipated within 7 days, the applicant is in need of a higher level of care than received in a Nursing Facility or ICF/MR and is not eligible for ALTCS. Record the projected discharge date whether discharge is imminent or not.

3. Ventilator dependent?

   This is defined as currently being on a ventilator at least 6 hours a day and for 30 consecutive days prior to the PAS date. **It may be necessary for the assessor to obtain information from multiple facilities to determine when the A/R started on the ventilator and if they meet the criteria.** The assessor must also complete the ventilator dependent work sheet if applicable.

   The A/R who is dependent upon a ventilator must have the PAS conducted by a team composed of a social worker and a registered nurse.

4. DD Status **(Select one)**

This field is to be completed for all applicants. The codes are defined as follows:

1 = Potential. A/R appears to have mental retardation, cerebral palsy, seizure disorder or autism, but has not been determined to be developmentally disabled by DES/DDD. S/he is referred to DES/DDD for evaluation. If DES/DDD has not determined DD status within 30 days, an EPD PAS must be completed and entered in CATS. The assessor may find it expedient to complete a DD PAS in addition to the EPD PAS pending DES/DDD eligibility status determination.

2 = DD. A/R has been identified by DES/DDD as developmentally disabled and is assessed using the DD assessment tool.

3 = DD in NF. A/R has been identified by DES/DDD as DD and resides in a NF. A/R is assessed using the EPD assessment tool.

4 = Non-DD. A/R is not diagnosed as DD or has a DD diagnosis but has been determined ineligible for DD services. A/R is assessed using the EPD assessment tool.

Refer to Appendix B1 for the PAS Tool Matrix by DD Status and Age.

For more information on DD status see ALTCS Eligibility Policy and Procedure Manual, Chapter 1500.

H. SUMMARY EVALUATION

In this section the assessor will summarize the overall condition and needs of the A/R. **The assessor should avoid making statements regarding eligibility, the advisability of any particular placement or need for institutionalization.** The following factors **must** be included when completing the summary if applicable to the case:

1. A brief description of the A/R's current major medical conditions and related problems; any conditions which are unstable or requiring significant treatment should be described. Any lab results, vital signs and other pertinent data should be noted;

2. Functional and developmental limitations and capabilities;

3. Formal and informal support system (e.g., describe formal services received such as therapies, or any informal services or support provided by relatives, neighbors, and friends);

4. Communication capabilities and sensory status (describe any significant sensory impairments);

5. Significant behavior problems and cognitive abilities (describe the impact upon health status and caregiving);

6. Nutritional status (e.g., chewing or swallowing problems, unusual eating patterns, major fluctuations in weight);

7. Environmental conditions;

8. Information on other sources of assistance given to A/R; and

9. Any other information the assessor feels is necessary to document including statements made by the A/R or caregiver such as what services are desired, any unmet needs observed or described.

The assessor should avoid statements which reflect any personal value judgments or biases.

I. ELIGIBILITY REVIEW REQUESTED?

The assessor should indicate whether or not a review is requested. Eligibility review is an integral part of the PAS assessment process. It is designed to address those A/Rs whose score outcome is not thought by the assessor to be a complete reflection of the A/R's need for an ICF/MR level of care.

An A/R who needs the entry level of care will require care greater than what is considered supervisory or custodial care and may present a combination of the following needs or impairments:

1. Requires 24 hour supervision;

2. Requires an intensive, multidisciplinary, continuous training program;

3. Requires a trained caregiver;

4. Requires regular medical monitoring;

5. Requires intervention for significant behavior problems;

6. Has significant impairment in development or independent living skills; and

7. Has impaired communication.

Eligibility reviews may occur for A/Rs who score either below or above the entry level scoring threshold. A/Rs may have impairments in some aspects (as described above) that "overshadow" their strengths in other areas. These reviews will usually be performed by a physician consultant or an administrative process. No A/R will be determined ineligible by an administrative process.

Reviews **must** be requested for:

- Ineligible cases scoring 38 or more on initial PAS.

- All ALTCS clients who do not meet threshold score for ALTCS or the Transitional program on reassessment.

- **All children under 6 months of age and EPD children under 6 years of age.**

Reviews **may** be requested for but are not limited to these cases:

- A/R does not meet threshold score but the assessor thinks the A/R may be at risk of institutionalization;

- A/R meets threshold score but has a psychiatric condition (includes chemical dependence) and does not have a non-psychiatric medical condition or developmental disability that by itself or in combination with the psychiatric condition places the A/R at risk of institutioalization;

- A/R requests a hearing;

- A/R meets the threshold score on an initial ALTCS application and is already a member of an AHCCCS health plan and appears to need less than 90 days of convalescent care; and

- Atypical cases: traumatic brain injuries, HIV/AIDS, specialized treatments, e.g., halo brace, body cast, any cases requiring extensive and complex medical care, the dually diagnosed (SMI/MR).

Signature and Title

Assessors signature and title as well as the date the PAS tool was completed should be filled in here.

Completion Time (in minutes)

The total amount of time it takes for the assessment to be completed. This includes time in interview, related phone calls and medical record review.

Travel Time (in minutes)

The total time for the assessor to travel from a previous destination to the current appointment and any related trips necessary to obtain records. When the assessor returns to the office, that time should be included in the last appointment. If multiple appointments are completed in the same facility, attribute only a fair share of the travel time to each appointment.

IV. PHYSICIAN'S ELIGIBILITY REVIEW

A. REASON REQUESTED

When requesting an eligibility review, the assessor should provide a specific reason based on the A/R's functional and medical conditions. Any information recorded must be factual and objective. Do not suggest an eligibility decision. Upon requesting an eligibility review, the assessor should provide the reviewer with current documentation pertinent to the A/R's condition, if available. Documentation should be selected for its ability to **CLARIFY** the current medical condition. **If this documentation is NOT available note that in this section.**

This documentation may include:

- History and Physical;
- Discharge summary if the A/R was hospitalized;
- Consultations by specialists (e.g. psychological, neurological or cardiological);
- Therapy notes;
- Nursing notes only if addressing a specific incident or condition;
- 3 month seizure diary and incident report log;
- Test results such as x-ray, laboratory, EEG, EKG or MRI results;
- Progress notes;
- Prior PAS (**ALL** prior PASs for children under 6); and
- Specialized treatment plan and progress notes (e.g., from vocational or behavioral programs).

B. ELIGIBILITY REVIEWER'S SUMMARY

In this section the reviewer determines, independent of score, if the A/R is at immediate risk of institutionalization in an ICF/MR (or NF when applicable). The summary will describe significant factors that determined eligibility and may include:

- A brief summary of the significant medical conditions.

- Discussion of the extent of the impact the current medical condition has upon physical/mental functioning.

- A prognosis with an estimate of continued level of functioning or disability. This may include an opinion on whether the applicant may be served adequately through supervisory care facilities, periodic outpatient care or intermittent hospital stay.

  In conducting the review, the reviewer may consider all available information from the PAS as well as any additional documentation provided by the assessor. The reviewer may call to discuss the case with the assessor. In making the determination, the reviewer may consider several areas such as functional limitations, cognitive deficits, stability of medical conditions, number, frequency and complexity of treatments, to list a few. The reviewer may place a different degree of significance on factors within each individual case. The reviewer must look at the case from the overall perspective of risk of institutionalization.

Review Results

After the review is completed, the reviewer will indicate the appropriate decision, eligible or ineligible.

LOC (level of care)

The reviewer will **indicate** the recommended LOC for all A/Rs considered eligible. For more information on LOC refer to Section VI of this manual.

Reviewer's Signature and Title

The reviewer's signature, title and date the review was completed should be indicated.

V. POSTHUMOUS PAS AND REASSESSMENTS

A. POSTHUMOUS PAS

In some instances an initial PAS may need to be completed after the applicant has expired. The applicant may have died after the application has been made, or in some cases a representative may have applied for the deceased applicant.

If the EI is aware that the applicant is deceased, this information will be put on the PAS referral and the date of death will appear on the PAS Intake Notice. In some cases, the applicant may die after the PAS referral has been made, and the EI may be unaware of the death. In that case, the PAS assessor will be responsible for notifying the EI of the death and source of this information.

Although the posthumous PAS may be an initial PAS, there are limitations on information availability and applicability. **A deceased applicant must have been placed in an ICF-MR or NF during the application month in order to be considered PAS eligible.** If the deceased A/R was in an ICF-MR or NF at any time during the assessed month, indicate ICF-MR or NF under "Usual Living Arrangement" in Section I., subpart C. CATS will identify the posthumous PAS by comparing the PAS date to the date of death. **(Note: a free-standing Hospice meets the requirements of a NF).**

B. REASSESSMENTS

PAS reassessments are required to determine continued eligibility for ALTCS. The same basic PAS criteria must be met in order for eligibility to continue, that is the A/R must continue to be at risk of institutionalization at an ICF-MR or NF level. Any changes in score or condition **must** be explained in comments or in the summary. Each reassessment should give a complete description of the A/R's current medical and functional status. To insure consistency and to prepare for the interview it is necessary to review the PAS file or CATS screens prior to conducting a reassessment.

Prior to dispositioning an ineligible reassessment the assessor must have contacted the case manager to obtain collateral information and to discuss the potential ineligibility.

For more information on Reassessments, see ALTCS Eligibility Policy and Procedure Manual, Chapter 1500.

VI. SCORING

Scoring will be based on functional and medical components that will vary depending on the tool used. The eligibility threshold on all the tools is 40. A computer-generated score sheet should be printed after each PAS is entered in CATS.

A. DISPOSITIONING

Before dispositioning a case the assessor **must** review the system to ensure accuracy of data entry on all screens. All scores must be reviewed for accuracy and the content of comments and summaries must also be reviewed. **If the assessor completing the PAS is not available to disposition the PAS, whoever dispositions the PAS is responsible for reviewing and ensuring the accuracy of the information defined above.**

Before dispositioning a case that has had a Physician Review completed, the assessor must review the Physician's comments. If the assessor disagrees with the decision, the case should not be dispositioned and should be discussed with a supervisor, who will review it with the Regional/Branch Manager and may refer it to the ALTCS Medical Eligibility Manager for review.

B. REVIEW CODES

Codes on the CATS Computer Screen CA070 show the type of review requested:

0 = No Review Necessary
1 = Routine Physician Review
2 = Pending Hearing
3 = Hearing Decision
4 = PARC (PAS Administrative Review Committee)
5 = ALTCS Administrative Review
6 = Psychiatric Physician Review (obsolete)

C. LEVEL OF CARE

After the PAS has been entered into the CATS system a LOC will be assigned by the computer or the eligibility reviewer. The LOC for DD clients will be:

M = ICF-MR/Intermediate Care Facility for the Mentally Retarded
V = Skilled/SNF-3 Ventilator Dependent
T = ALTCS Transitional Program.

The physically disabled children assessed with DD PAS tools may be at **ANY LEVEL OF CARE EXCEPT M (ICF-MR).**